DEPARTMENT OF HEALTH AND HUMAN SERVICES INTED: 07/18/2007 HEALTH DE CHARLES BORNEY
ADMINIS RACEMPLETED CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING JUL 25 P 0412/2007 B. WING 09G179 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 5701 13TH STREET, NW METRO HOMES WASHINGTON, DC 20011 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE תו (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX (X5) COMPLETION PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) W 000 INITIAL COMMENTS W 000 A recertification survey was conducted from July 11, 2007 through July 12, 2007. The survey was initiated using the fundamental survey process. A random sample of two clients was selected from a resident population of four females with various disabilities. The survey findings were based on observations in the group home and one day program, and interviews with clients, residential, day program, nursing and administrative staff. Review of records, including investigations of unusual incidents was also conducted. 483.410(a)(1) GOVERNING BODY W 104 The governing body must exercise general policy. budget, and operating direction over the facility. This STANDARD is not met as evidenced by: Based on observations, interviews and review of records, the facility's governing body provided W 104 general operating direction over the facility, a. Front door bell has been fixed except in the following areas: b. Back bedroom door bell has been fixed c. Towel bar replaced in the first BR The finding includes: d. Towel bar replaced in the second BR e. Missing globe light in laundry room has The governing body failed to ensure the been replaced 7/23/07 maintenance of the facility's environment, as f. Broken Dryer has been removed evidenced by: g. Unused walkers were removed h. Broken chair removed a. Front door bell alarm button loose; i. Broken vacuum cleaner removed b. Back bedroom door bell alarm button loose; In the future the Agency will ensure that the facility's environment is well maintained Missing towel bar in the first bathroom on the and safe and has instituted an Environmental first floor;

шъл

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

d. Missing towel bar in the second bathroom on

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID; DZ7Y11

Facility ID: 09G178

audit to be done monthly - see attached

TITLE

If continuation sheet Page 1 of 22

(ME) DATE

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	ENT OF DEFICIENCIES N OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) ML A. BUIL	ULTIPLE CONSTRUCTION DING	(X3) DATE	E SURVEY PLETED
		09G179	B. WIN	3	0.5	400000
ł	PROVIDER OR SUPPLIER HOMES			STREET ADDRESS, CITY, STATE, ZIP C 5701 13TH STREET, NW WASHINGTON, DC 20011		<u>/12/2007</u>
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO	N SHOULD BE E APPROPRIATE	COMPLETION
	the first floor; e. Missing globe light f. Broken dryer in law g. Several unused we basement; h. Broken chair ston i. Broken vacuum cle basement. 483.420(a)(2) PROTI RIGHTS The facility must ensure the facility parent (if the client is of the client's medical and behavioral status treatment, and of the client or their leg of the client's medical and behavioral status, treatment, and the right two of two clients in the Client #2) The findings include: 1. Observation of the medical and behavioral status, treatment, and the right two of two clients in the Client #2)	at in the laundry room; undry room; alkers stored in the ed in the basement; and eaner stored in the ECTION OF CLIENTS ure the rights of all clients, must inform each client, a minor), or legal guardian, condition, developmental attendant risks of right to refuse treatment. not met as evidenced by: interview and record failed to ensure the right of all guardian to be informed condition, developmental attendant risks of int to refuse treatment for the sample. (Client #1 and	W 124		consent nsure that all or legal	7/23/07

U//18/2007 US:00 PAA 2024428450

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLI A. BUILDING	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		09G179	B. WING		07/1	2/2007	
NAME OF F	ROVIDER OR SUPPLIER		570	ET ADDRESS, CITY, STATE, ZIF 1 13TH STREET, NW ISHINGTON, DC 20011	CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X\$) COMPLETION DATE	
W 124	8:00AM, revealed mg by mouth. Inte July 11, 2007 at at that the medicatio management. Re orders dated June approximately 10:50 mg by mouth the product of the province of the province of the product of	Client #1 received Loxitane 50 rview with the nursing staff on opproximately 8:01AM revealed in was prescribed for behavior view of the client's physicians 1, 2007 on July 11, 2007 at 200 AM revealed that Loxitane wice a day and Atarax 100mg rening was incorporated in a Plan (BSP) dated April 12, behaviors associated with on, verbal aggression, pubic reaming. Interview with the retardation Professional 1, 2007 at approximately that Client #1 did not have a urther interview revealed that it signs the consents for her as, however he was not the	W 124				

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ł	AULTIP ILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		<u>39</u>
		09G179	B. Wil	NG		לח	14 9 100 00	
METRO	PROVIDER OR SUPPLIER			570	ET ADDRESS, CITY, STATE, ZIP CO 01 13TH STREET, NW ASHINGTON, DC 20011		/12/2007	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD RE	(X5) COMPLETI DATE	
W 125 R	mg by mouth and Lo Interview with the nual approximately 8:3 medication was presonangement. Review orders dated June 1 approximately 10:15 mg and Loxitane 50 was incorporated in a February 11, 2007, to associated with self-destruction, physical aggression, non-comprying. Interview with at approximately 10:2 did not have a legal grevealed that Client #2 consents for her medicate was not the client for the was not the client for a proximately 10:2 did not have a legal grevealed that Client for several that Client for a proximately 10:2 did not have a legal grevealed that Client for a proximately 10:2 did not have a legal grevealed that Client for a proximately 10:2 did not have a legal grevealed that Client for a proximately 10:2 did not have unable to grey 10:2 did not have unable t	lient #2 received Clozaril 300 bxitane 50 mg by mouth. Irsing staff on May 15, 2007 itAM revealed that the scribed for behavior ew of the client's physicians and revealed that Clozaril 300 mg by mouth twice a day a corresponding BSP dated address behaviors injurious behavior, property aggression, verbal appliance, screaming and a the QMRP on July 11, 2007 the QMRP on July 11, 2007 the QMRP on July 11, 2007 the QMRP interview 2's mother signed the ical procedures, however it's legal guardian. It's Psychological abruary 11, 2007 on July 11, 71:50 PM indicated that the rant informed consents in a more regarding medical ocumented evidence that lient #2 or a resentative, as appropriate, and risks of treatment and risks of treatment and been obtained from a						
		e are rights of all dirents.						

DEPAR'TMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION	(X3) DATE S COMPL	
		09G178	B. WING		07 <i>l*</i>	12/2007
NAME OF F	PROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP (5701 13TH STREET, NW WASHINGTON, DC 20011		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
W 125	Therefore, the faci individual clients to of the facility, and a	age 4 lity must allow and encourage exercise their rights as clients as citizens of the United States, to file complaints, and the right	W 125	5		
	Based on staff interfacility failed to ensideveloped to information guardian of the clie treatment, and the	is not met as evidenced by: rview and record review, the ure that a system had been n each client, parent or legal nt's behavioral status, risk of right to refuse treatment for its in the sample. (Client #1)		W 125 The facility has begun the g process by completeing the - Guardianship Questionnai - Surrogate agreement to gi See attached	following re ve consent	7/23/07
	Professional (QMR approximately 10:16 brother was active is medical consult, da at approximately 2:5 #1's brother signed colonoscopy, however guardian. The review Assessment dated a 2007 at approximate client is not compete informed decisions of psycological treatment the client had a legal	tualified Mental Retardation P) on July 11, 2007 at 5 AM revealed that Client #1's in her life. Review of a ted July 5, 2007 on July, 2007 50PM revealed that Client the consent for a ver he was not the legal w of Client #1's Psychological April 11, 2007 on July 12, aly 10:45AM indicated that the cent to make independent or concerning medical and cent. There was no evidence lly-sanctioned guardian lealth care decision-maker to		In the future the agency will clients will have a substitute guardian or entity in place for medical procedures and physical restraint procedures	ed or legal or all consents chemical or	
	483.420(a)(7) PROT RIGHTS	ECTION OF CLIENTS	W.130			,

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1, ,			COMPLETED	
	09G179	B. WIN	ıc	07/1	2/2007	
PROVIDER OR SUPPLIER	,		STREET ADDRESS, CITY, STATE, ZIP CO 5701 13TH STREET, NW WASHINGTON, DC 20011	DDE	1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 -	
(EACH DEFICIENCY	MUST BE PRECEDED BY FULL		X (EACH CORRECTIVE ACTION	4 SHOULD BE	(X5) COMPLETION DATE	
The facility must en Therefore, the facility treatment and care This STANDARD is Based on observation ensure privacy was personal needs for the facility. (Client # The finding include: On July 11, 2007 at Client #1 was obserwhile the bathroom commode and Client front door of the face entered the bathroom of close the door, revealed that the client was ensured that morning staff enwhile using the bath 483.420(d)(2) STAF CLIENTS The facility must ensured injuries of unknown immediately to the a officials in accordance established procedur.	sure the rights of all clients. ty must ensure privacy during of personal needs. Is not met as evidenced by: on and interview, the failed to provided during care of one of two clients residing in (1) approximately 8:25 AM, ved sitting on the commode door was open. The at #1 were visible from the illity. When nursing staff on to assist the client, they did interview with nursing staff ent needed reminders to close used the bathroom. Nursing ved offering Client #1 a ng. There was no evidence sured the client's privacy room. If TREATMENT OF sure that all allegations of ct or abuse, as well as source, are reported dministrator or to other ce with State law through res.	·	W 130 The Facility has retrained all including nursing staff regard rights and privacy. In the future the Agency will staff have regular and period training in all DDS Policies a	ensure that all ic on going and Procedures.	7/23/07	
Based on interview a	and record review, the facility					
	Continued From partnered the facility (Client #1 was observable the bathroom commode and Client front door of the facility door close the door revealed that the client while using the bath 483.420(d)(2) STAF CLIENTS The standard in the same that a client was a commode and client while using the bath 483.420(d)(2) STAF CLIENTS The facility must ensure that more interest of unknown immediately to the accordance stablished procedu.	DENTIFICATION NUMBER: 09G179 PROVIDER OR SUPPLIER HOMES SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 5 The facility must ensure the rights of all clients. Therefore, the facility must ensure privacy during treatment and care of personal needs. This STANDARD is not met as evidenced by: Based on observation and interview, the failed to ensure privacy was provided during care of personal needs for one of two clients residing in the facility. (Client #1) The finding include: On July 11, 2007 at approximately 8:25 AM, Client #1 was observed sitting on the commode while the bathroom door was open. The commode and Client #1 were visible from the front door of the facility. When nursing staff entered the bathroom to assist the client, they did not close the door. Interview with nursing staff revealed that the client needed reminders to close the door when she used the bathroom. Nursing staff were not observed offering Client #1 a reminder that morning. There was no evidence that nursing staff ensured the client's privacy while using the bathroom. 483.420(d)(2) STAFF TREATMENT OF	DENTIFICATION NUMBER: A. BUIL DISCRIPTION A. BUIL DISCRIPTION B. WIN DENOMINES SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 5 The facility must ensure the rights of all clients. Therefore, the facility must ensure privacy during treatment and care of personal needs. This STANDARD is not met as evidenced by: Based on observation and interview, the failed to ensure privacy was provided during care of personal needs for one of two clients residing in the facility. (Client #1) The finding include: On July 11, 2007 at approximately 8:25 AM, Client #1 was observed sitting on the commode while the bathroom door was open. The commode and Client #1 were visible from the front door of the facility. When nursing staff entered the bathroom to assist the client, they did not close the door. Interview with nursing staff revealed that the client needed reminders to close the door when she used the bathroom. Nursing staff were not observed offering Client #1 a reminder that morning. There was no evidence that nursing staff ensured the client's privacy while using the bathroom. 483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. This STANDARD is not met as evidenced by:	DENTIFICATION NUMBER: 09G179 STREET ADDRESS, CITY, STATE ZIP CC 5701 13TH STREET, NW WASHINGTON, DC 20011 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 5 The facility must ensure the rights of all clients. Therefore, the facility must ensure privacy during treatment and care of personal needs. This STANDARD is not met as evidenced by: Based on observation and interview, the failed to ensure privacy was provided during care of personal needs for one of two clients residing in the facility. (Client #1) The finding include: On July 11, 2007 at approximately 8:25 AM, Client #1 was observed sitting on the commode while the bathroom door was open. The front door of the facility. When nursing staff entered the bathroom, Nursing staff revealed that the client needed reminders to close the door when she used the bathroom. Nursing staff were not observed offening Client #1 a reminder that morning. There was no evidence that nursing staff entered the bathroom. 483 420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. This STANDARD is not met as evidenced by:	DENTIFICATION NUMBER DOGGT79 ROVIDER OR SUPPLIER HOMES SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) COntinued From page 5 The facility must ensure the rights of all clients. Therefore, the facility must ensure privacy during treatment and care of personal needs. This STANDARD is not met as evidenced by: Based on observation and interview, the failed to ensure privacy was provided during care of personal needs for one of two clients residing in the facility. (Client #1) The finding include: On July 11, 2007 at approximately 8:25 AM, Client #1 was observed sitting on the commode while the bathroom to assist the client, they did not close the door, Interview with nursing staff revealed that the client needed reminders to close the door when she used the bathroom. Nursing staff revealed that the client needed reminders to close the door when she used the bathroom. Nursing staff revealed that the client needed reminders to close the door when she used the bathroom. Nursing staff revealed that the client needed reminders to close the door when she used the bathroom. Nursing staff revealed that the client needed reminders to close the door when she used the bathroom. Nursing staff were not observed offering Client #1 a reminder that morning. There was no evidence that nursing staff ensured the client's privacy while using the bathroom. ### 430 W 130 The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. This STANDARD is not met as evidenced by:	

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/18/2007 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		09G179	B. WING		07/	12/2007
NAME OF F	PROVIDER OR SUPPLIER			REET ADDRESS, CITY, STATE, ZIP COD 5701 13TH STREET, NW WASHINGTON, DC 20011	·	<u> </u>
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE ADEFICIENCY)	SHOULD BE	(X\$) COMPLETION DATE
	health or safety to grequired by DC register Section 3519.10). The finding includes Review of an unusure 15, 2007 on July 11 AM revealed that Clabdominal pain and emergency room for Review of an emergency room for Review with the Q Professional (QMRF was not forwarded to (DOH). There was a this incident had been agencies as required 483.430(a) QUALIFI RETARDATION PREACH client's active to integrated, coordinated qualified mental retainted. This STANDARD is Based on observation review the facility fail treatment program wand monitored by the Retardation Professi	ats that pose a risk to client povernmental agencies, as culation (22 DCMR Chapter 35 culation (22 DCMR Chapter) 7:45 culation and treatment (25 culation and treatment (26 culation and treatment (27 culation and treatment (28 culation and treatment (29 culation and treatment (29 culation and treatment of Health (20 culation and the decidence that an reported to governmental culation and monitored by a relation professional. The professional culation and treatment program must be seed and monitored by a relation professional. The professional culation and treatment program culation professional (20 culation decident) for two of two (20 culation decident) for two of two (20 culation decident). (Client #1 and Client #2)	W 159	Incident Report was faxed to I See attached receipt of fax. In the future the Agency will e there is prompt reporting of all required by DC Regulations. T has instituted a system and has Management Unit which meets review all incidents for the pre All staff, QMRP and nursing stretrained in Incident Managem and Procedures. See attached	nsure that Incidents as The Agency an Incident s weekly to ceding week, taff were	7/23/07

MAC.

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	()	A. BUILDING		TE SURVEY MPLETED	
		09G179	B. WING _		07/1	2/20 07	
METRO	PROVIDER OR SUPPLIER		5	REET ADDRESS, CITY, STATE, ZIP CODE 5701 13TH STREET, NW NASHINGTON, DC 20011	: :		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIÊNCIES Y MUST DE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SE CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(XS) COMPLETION DATE	
W 159	1. Cross Refer to Vensure that incider risk to client health agencies, as requiped the comment of the could be quantifiable. 3. Cross Refer to Vensure that Clients (IPP) objectives we could be quantifiable. 3. Cross Refer to Vensure that Clients (IPP) objectives we could be quantifiable. 4. Cross Refer to Vensure that Clients (IPP) objectives we and accurately on forms. 5. The QMRP fails Psychologist to ensure that Clients (IPP) objectives we and accurately on forms. 5. The QMRP fails Psychologist to ensure that Clients (IPP) dated Februat approximately 12 recommendation for commendation for commendation for client #2 could early which she did not expected the could early which she did not expected the commendation of compliance, so the compliance of the compliance o	N153. The QMRP failed to his were reported that posed a for safety to governmental red by DC regulation (22 Section 3519.10). N231.1 The QMRP failed to this individual Program Plan ere stated in a manner which only measured. N231.2 The QMRP failed to the thight of the thigh of the thight of th	W 159	W 159 1. – Cross refer to W 153 2. – Client #1's IPP has been reensure that all objectives can be measured. See attached IP3. – Client #2's IPP has been revensure that all objectives can be measured. See attached IP4. – Client #3's IPP has been revensure that all objectives can be measured. See attached 5. – The BMP for client #2 - for program has been discontinued a has been amended. See attached B In the future the QMRP will ensclient programs are reviewed wire at least every 6 mths to ensure the receive the appropriate programs program supplies and monitoring. The Agency has instituted a mor Audit System to ensure that all crecords are reviewed monthly. See attached A	e quantifiably PP Vised to quantifiably P Vised to quantifiably The vised to quantifiably The token and the BMP MP Ure that all the the IDT that all clients and g Inthly QMRP Client ISP	7/23/07	

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	IT OF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI		LE CONSTRUCTION	(X3) DATE COMP	SURVEY
		09G179	B. WIN	IG		07/	/12/2007
METRO	PROVIDER OR SUPPLIER			576	ET ADDRESS, CITY, STATE, ZIP COD 01 13TH STREET, NW ASHINGTON, DC 20011		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	of five stars she cot grab bag. Interview Client #2 did have a program, however rinterview revealed think that the program revised simple tokel developed. There withat Client #2 was picalendar program. 483.430(b)(5) PROF SERVICES Professional program certified, or registered professional services she practices. This STANDARD is Based on staff interview are did that the faction of twelve professional columbia Laws. The finding includes: Interview with the Quiprofessional (QMRP) approximately 3:00Prior the Psychiatrist with the facility failed to he available in accordant Occupation Revision 12 Section 3-1205.13	alid pick out an item from a with the QMRP revealed that a simple token calendar to data was provided. Further nat the Psychologist did not an was beneficial and a calendar program was being as no documented evidence rovided with a simple token resided with the State in which he or review and record review rewards are licensed and/or review rewards are licensed and/or review revealed that the license as not available for review ave the current license with the Health Act (HORA) Title 3 Chapter ("Each licensee shall inspicuously in any and all	W 17		W 170 See attached License for Psy	chiatrist	7/23/07

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES TATEMENT OF DEFICIENCIES TOTAL PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCITS AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M	ULTIPLE CONSTRUCTION DING	(X3) DATE S COMPL	
		09G1 7 9	B. WIN	G	07/1	2/2007
METRO	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST 5701 13TH STREET, NW WASHINGTON, DC 20		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFI TAG	((EACH CORRECT CROSS-REFERENÇ	LAN OF CORRECTION TVE ACTION SHOULD BE LED TO THE APPROPRIATE FICIENCY)	COMPLETION DATE
W 189	The facility must pro initial and continuing	F TRAINING PROGRAM pride each employee with g training that enables the m his or her duties effectively, patently.	W 1	W 189 1. Cross refer to W		7/23/07
	Based on observation review, the facility facili	s not met as evidenced by: on, interview and record ailed to ensure that each ded with initial and continuing if the employee to perform his vely, efficiently, and		and Safety	attached	
	ensure that staff had on reporting unusual of Health (DOH). 2. Cross Refer to Wensure that staff had implementing emerging. 3. Cross Refer to Wensure that staff der recognizing signs and Client #1. 4. Cross Refer to Wensure that staff der implementing fall presented.	153. The facility failed to directive effective training incidents to the Department 192. The facility failed to directive effective training interesting measures. 194.1. The facility failed to monstrated competency in disymptoms of illness IN 194.2. The facility failed to monstrated competency in ecautions for Client #1.		5. All staff were re to Evacuation drills and and Procedures. 6. All staff were train procedures and the Community Manager have development of the Manager will ensure to training and periodic	Is risk assessments and See attached rained in Fire d Fire and Safety Policy See attached ned in Fire evacuation MRP and House oped a schedule for fire times and scenarios. See attached	
	ensure that staff had	140. The facility failed to received effective training cuation drills quarterly on all		The Agency is in the a Training Dept.	Process of developing	

HKA

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		, ,			ATE SURVEY OMPLETED	
		D9G179	B. WING		07/1	12/2007
NAME OF F	PROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, 21F 5701 13TH STREET, NW WASHINGTON, DC 20011		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION ((EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
W 189	,	age 10 W441. The facility failed to	W 189	•		
W 192	ensure that staff h on documenting e conditions.	ad received effective training vacuation drills under varied AFF TRAINING PROGRAM	W 192	2		
		o work with clients, training is and competencies directed ith needs				
	Based on observati review, the facility implement emerge	is not met as evidenced by: tion, staff interview and record failed to effectively train staff to ency measures for four of four y. (Clients #1, #2, #3 and #4)		W 192 1 &2 – See attached CPR a certifications for current standard Agency has instituted a condata base to monitor all per a monthly basis to ensure the certifications are always manufacturent status.	aff. mputerized staff rsonnel records on hat on going	7/23/07
	Professional (QMR approximately 11:0 was not trained in 0 12, 2007 at approx five out of twelve st certifications. Therevidence that all dispersions.	e Qualified Mental Retardation (P) on July 12, 2007 at (I) AM revealed that all staff CPR. Record review on July imately:05 AM revealed that taff did not have current CPR record react care staff had CPR to CPR certifications.				
-	approximately 11:1 was not trained in F July 12, 2007 at ap revealed that five o have current First A no documented evi	e QMRP on July 12, 2007 at 0 AM revealed that all staff First Aid. Record review on proximately 11:15 AM ut of twelve staff staff did not had certifications. There was dence that all direct care staff g and current First Aid				

PRINTED: 07/18/2007 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 09G179 07/12/2007 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 5701 13TH STREET, NW METRO HOMES WASHINGTON, DC 20011 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX COMPLETION REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) W 192 Continued From page 11 W 192 certifications W 194 483.430(e)(4) STAFF TRAINING PROGRAM W 194 Staff must be able to demonstrate the skills and techniques necessary to implement the individual program plans for each client for whom they are responsible. W 194 1 &2 - Cross refer to W 189 - #2, 3 & 4 This STANDARD is not met as evidenced by: Based on observations, staff interviews and the review of records, the facility staff failed to demonstrate competency in recognizing signs and symptoms of illness and implementing fall precautions in one of two clients in the sample. (Ciient #1) The findings include: 1. The facility failed to effectively train staff to recognize signs and symptoms of illness in Client #1 as evidenced by: Upon entering the facility on July 11, 2007 at approximately 7:54 AM, Client #1 was observed to be screaming, crying and pointing to the second toe on her left foot. Attempts to interview Client #1 were not successful because the client continued to scream and cry. Interview with Direct Care Staff #1, Direct Care Staff #2 and Direct Care Staff #3 on July 11, 2007 at approximately 7:55AM revealed that they had no knowledge of

why Client #1 was screaming/crying and pointing to the second toe on her left foot. Further interview revealed that the direct care staff had not informed the Licensed Practical Nurse (LPN)

who was in the facility that Client #1 was screaming/crying and pointing to the second toe

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: A. BUILDING		(X3) DATE SURVEY COMPLETED			
		09G179	B. WI	NG		07/1	12/2007
NAME OF	PROVIDER OR SUPPLIER			570	ET ADDRESS, CITY, STATE, ZIP CODE 11 13TH STREET, NW ASHINGTON, DC 20011		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREI (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	DULD BE	(X5) COMPLETION DATE
	on her left foot. Durobservation on July Client #1 was obser pointing to the seco screaming. Interview 2007 at approximate had assessed Client Registered Nurse (F July 11, 2007 at approximate the LPN had not Client #1 was pointing to foot and scream RN revealed that shouth three times a pain. Further interview assessed that the mand right second to she would continue (Note: Observation Registered Nurse (Rapproximately 5:00P Staff #1, Direct Care Staff #3 participated signs and symptoms 2. The facility failed to implement fall precase videnced by: Client #1 was observed Manager on July 11, 9:00AM that she had night and that she had might and that she had immediately call Direct Call precase immediately call Direct Call precase manager on July 11, 9:00AM that she had might and that she had migh	ing medication pass 11, at approximately 7:56 AM, yed gesturing to the LPN and not toe on her left foot and with the LPN on July 11, ely 8:10 AM revealed that she t #1 and had notified the RN). Interview with the RN on proximately 9:30AM revealed diffied her via telephone that high to the second toe on her ing. Further interview with the e had notified the Primary P) at approximately 8:20AM is and that Motrin 600mg by day had been ordered for ew revealed that the RN had alibeds around Client #1's left is were slightly red and that to monitor Client #1. and interview with the RN in and that the RN in a	W	194			

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA . IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		1	(X3) DATE SURVEY COMPLETED	
		09G179	B. WING)	07/	12/2007	
	PROVIDER OR SUPPLIER		5	STREET ADDRESS, CITY, STATE, ZIF 5701 13TH STREET, NW WASHINGTON, DC 20011			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT OROSS-REFERENCED TO T DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
W 194	them that she was oregarding Client #1' the night of July 11, revealed that the Hothe incident and begofficials per facility pon July 11, 2007 at revealed that the Poleg x-rays for Client to the emergency ro Review of Client #1' April 11, 2007 on July 10:28AM revealed to osteoporosis. Review of osteoporosis. Review Management Care Foundation of the clied that the clied documented as a ris radiology reports dat 2007 at approximate Client #1 had not sur leg fractures.	conducting an investigation is allegation of haven fallen on 2007. Further observation cuse Manager documented gan to notify the designated policy. Interview with the RN approximately 3:00 PM CP ordered bi-lateral hip and #1 and she was transported om via the facility van. Is medical assessment dated by 12, 2007 at approximately that the client had a diagnosis view of Client #1's Health Plan dated April 22, 2007 on roximately 10:51AM ent had fall precautions is a rea. Review of the ged July 11, 2007 on July 12, ally 2:30PM revealed that stained any bi-lateral hip or	W 19	4			
	July 11, 2007 at applithat Direct Care Staff Direct Care Staff #3 training on fall precal 483.440(c)(4)(iii) IND The objectives of the must be expressed in provide measurable. This STANDARD is Based on interview at failed to ensure that a	and interview with the RN on roximately 5:00PM revealed if #1, Direct Care Staff #2 and participated in an in-service utions on July 11, 2007] IVIDUAL PROGRAM PLAN individual program plan in behavioral terms that indices of performance. Interview the facility all client program objectives ovide measurable indices of	W 231				

HLV.

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/18/2007 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED	
		09G179	E. WING		07/1	2/2007
METRO	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP C 5701 13TH STREET, NW WASHINGTON, DC 20011			
(X4) ID PREFIX TAG	(EACH DEFICIENT	TATEMENT OF DEFICIENCIES CYMUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
W 231	performance for the (Client #1 and Client #1	wo of two clients in the sample. ent #2) de: It #1's Individual Program Plan June and July 2007 on July 12, ately 1:45 PM included the management objective: Itake change and take item with In the Qualified Mental assional (QMRP) on July 12, ately 1:50PM it was It the program had multiple y and was not measurable. Itence that the measurement easurable indices of ich level. It #2's Individual Program Plan June and July 2007 on July 12, ately 1:55 PM included the management objective: Itake change and take item with In the Qualified Mental assional (QMRP) on July 12, ately 2:00PM it was It the program had multiple and was not measurable, ence that the measurement asurable indices of	W 231	W 231 1. Client #1 has had her IPP management revised to provi indices—see 2. Client #2 has had her IPP ensure the objectives are measure the objectives are measure that a staff have been in service programs and documentation	ide measurable e attached revised to asurable. e attached ed on the new	7/23/07

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILI	DING		(X3) DATE SURVEY COMPLETED	
<u></u>		09G179	B. WING	3	07/	12/2007	
METRO	PROVIDER OR SUPPLIER HOMES		STREET ADDRESS, CITY, STATE, ZIP CODE 5701 13TH STREET, NW WASHINGTON, DC 20011				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	DULD RE	(X5) COMPLETION DATE	
W 252	Continued From pa	ge 15	W 25	2 .	- <u> </u>		
	specified in client in	omplishment of the criteria dividual program plan documented in measurable		W 252 Client #2 – program for improviextremity strength. All staff have serviced on documentation, to enaccurate comments are document signify the actual number of accurate controls.	e been in isure that ted to	7/23/07	
This STANDARD is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure that each client's Individual Program Plan (IPP) objectives are documented consistently and accurately for one of the two clients included in the sample. (Client #2)				tasks, so that an accurate assessn made of the client's progress. See att	nent can be		
	The finding includes	,					
	Plan (IPP) dated Fet 2007 at approximate Client #2 had a goal strength. Further rev is not able to comple box for the date and section how much the Review of the IPP da 2007 at approximate	s had a Individual Program bruary 8, 2007 on July 12, aly 2:30PM revealed that to improve lower extremity lew revealed that if the client te task put a minus in the document in the comment e client accomplished. It is collection on July 12, by 2:35PM revealed that that umented in accordance with data collected was vs:				,	
) N 0 8	was no evidence that comment section how	minus was placed in the					
r	b) July 4 and 11, 200 of complete the fask	7- Staff documented "did " in the comment section for					

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		09G179	B. WING	r	07/1	2/200 7
NAME OF F	PROVIDER OR SUPPLIER		,	REET ADDRESS, CITY, STATE. ZIP CO 5701 13TH STREET, NW WASHINGTON, DC 20011	DE	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
W 322	the specified dates. In an interview with Retardation Profess 2007 at approximate acknowledged that the program as writt problem with the do There was no evide collected in accorda which was necessary of the client's program as written and sense at the client's program as written and general medical care. This STANDARD is Based on observation and general medical clients in the sample implement medical clients in the sample. The finding includes 1. The facility's med prescribe glucose medical clients in the sample with the Lien July 11, 2007 at a revealed that Client: Borderline Diabetes glucose measuremed	the Qualified Mental sional (QMRP) on July 12, ety 2:40 PM, it was the staff were implementing ten but that there was a cumentation. Ince that the data had been ince with the IPP for Client #2, by for a functional assessment ess. BICIAN SERVICES Invide or obtain preventive and e. Is not met as evidenced by: Incompany the provide eral care and failed to provide eral care and failed to protocols for one of two expenses for Client #2.	W 322		d on the POS. ed thas been uled. edical Activity dical follow viewed and the rly QA system es.	7/23/07

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 07/18/2007 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING B. WING 09G179 NAME OF PROVIDER OR SUPPLIER 07/12/2007 STREET ADDRESS, CITY, STATE, ZIP CODE **METRO HOMES** 5701 13TH STREET, NW WASHINGTON, DC 20011 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (X5) COMPLETION PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE DEFICIENCY W 322 Continued From page 17 W 322 revealed that the Primary Care Physician (PCP) did not indicate any blood glucose measurement perimeters. Review of the Client #2's physician's orders dated June 1, 200 on July 11, 20077 at approximately 2:35 PM revealed that blood glucose measurement perimeters were not prescribed for Client#2. There was no evidence that blood glucose measurement perimeters prescribed by the PCP. 2. Cross Refer to W331. The facility's nursing services failed to obtain a timely endocrinology appointment for Client # 2. 3. Cross Refer to W331. The facility's nursing services failed to obtain timely laboratory studies for Client #2 as recommended by the Endocrinologist. W 331 483.460(c) NURSING SERVICES W 331 The facility must provide clients with nursing W 331 services in accordance with their needs 1&2 - Cross refer to W 322 This STANDARD is not met as evidenced by: Based on staff interview and record review the facility failed to ensure nursing services in accordance with the needs of one of two clients in the sample. (Client # 2) The findings include: The facility's nursing services failed to ensure

that Client #2 returned to the endocrinology clinic

Review of an endocrine consult dated February 2, 2007 on July 12, 2007 at approximately 1:00PM revealed that Client #2 was recommended to

as recommended as evidenced by:

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		09G179	B. WING	· · · · · · · · · · · · · · · · · · ·			
ı	PROVIDER OR SUPPLIER			REET ADDRESS, CITY, STATE, ZIP 5701 13TH STREET, NW WASHINGTON, DC 20011		12/2007	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
	return to the endod In an interview with (LPN) on July 12, 2 it was acknowledge to the endocrine of no documented evito the endocrinolog recommended by the endocrinolog recommended by the Interview with approximately 1:15 was being schedule appointment on Augustimely laboratory streed and the endocrinologist of the endocrinologist Interview with approximately 1:00 four months as recommended by the evidenced by: Review of an endocrinologist at approximately 1:00 four months as recommended and the endocrinologist Interview with approximately 1:20 four months with approximately 1:20 four months as recommended in four months are recommended in four months and months are recommended in four months	crinology clinic in four months. In Licensed Practical Nurse 2007 at approximately 1:08 PM ed that Client #2 did not return inic in four months. There was idence that Client #2 returned gy clinic in four months as the endocrinologist. In the LPN on July 12, 2007 at PM revealed that Client #2 ed for an endocrinology gust 20, 2007] sing services failed to obtain udies for Client #2 as the Endocrinologist as crine consult dated February 2, 07 at approximately 1:02PM #2 was recommended to AIC laboratory study onths. In an interview with Nurse (LPN) on July 12, 2007 thave a Hemoglobin AIC formed in four months. There is evidence that Client #2 had aboratory study performed in mmended by the a.the LPN on July 12, 2007 at PM revealed that Client #2 of or a Hemoglobin AIC	W 331				
w 393	483.460(n)(1) LABO	RATORY SERVICES	W 393	<u> </u>			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		09G179	B. WING_		07/	12/2007	
METRO	PROVIDER OR SUPPLIER HOMES			REET ADDRESS, CITY, STATE, ZIP (5701 13TH STREET, NW NASHINGTON, DC 20011			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
W 393	Continued From pag	ge 19	W 393		 -		
		to provide laboratory services, meet the requirements of this chapter.					
	Based on observation review, the facility far requirements for per	not met as evidenced by: on, interview and record iled to ensure it met the forming glucose monitoring e clients who requires ent #2)		W 393 The agency has started the preeting the requirements to laboratory services See attache	provide	7/29/07	
	The finding includes:						
	on July 11, 2007 at a revealed that Client # Borderline Diabetes Glucophage 500mg of the LPN revealed that measurements utilized prescribed three times Qualified Mental Retain (QMRP) on July 11, 20 that the provider does waiver as required by Laboratory improvement Client #2's Medical (MAR) on July 11, 20 revealed that Client#2	censed Practical Nurse (LPN) approximately 2:30PM, 22 has a diagnosis of Mellitus and is prescribed every evening. Interview with at blood glucose ag a glucometer is as a week. Interview with the ardation Professional 2007, at 3:00 P.M. revealed and the number of the clinical ment Act (CLIA), Review of ation Administration Record of at approximately 3:10PM as prescribed finger sticks a levels three times a week.			·		
	of Health (DOH)iabor	s referred to the Department atory surveyor for an July 11, 2007 at 3:20 P.M.] ATION DRILLS	W 440				
	The facility must hold	evacuation drills at least					

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEME AND PLAN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MI	JLTIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED	
		09G179	B. WIN	G	07/12/2007		
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C 5701 13TH STREET, NW WASHINGTON, DC 20011		12/2007	
(X4) ID PREFIX TAG	(EACH DEI*ICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFD TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE APPROPRIATE	(X5) COMPLETION DATE	
W 440	Continued From pa	-	W 4	40			
	This STANDARD is Based on record reversecuation drills qua	s not met as evidenced by:		W 440 Cross refer to W 189 – 5&6			
	The finding includes	:					
	Professional (QMRF	ualified Mental Retardation) on July 11, 2007 at AM revealed that the staff llows:	Sub				
	Day shift: 8:00 AM- t Evening shift: 4:00 Pt Night shift: 12:00 Pt	ill clients go to day program M to 12:00 PM M to 8:00 AM			÷		
-	from August 2007 to at approximately 10: were not conducted first quarter. There w	ble fire drill records dated June, 2007 on July 11, 2007 35 AM revealed that fire drills on the day shift during the ras no evidence that every inducted an evacuation drill at					
W 441	483.470(i)(1) EVACL	ATION DRILLS	W 44	1 W 441			
	varied conditions.	evacuation drills under	•	Facility has developed a sche varying times and scenarios to evacuation via all available estaff was in serviced on property.	o include gresses. The er conduction	7/23/07	
	Based on staff intervi	not met as evidenced by: ew and record verification, old evacuation drills under		of Fire drills and accurate doo The Agency has instituted a n Environmental and QMRP Q.	nonthly A system – to		
	The finding includes:			ensure the appropriate Policy Procedures are followed.			
	On July 11, 2007 at a	pproximately 10:45AM		See atta	ached		

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

AND PLAN	AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
114145 05		09G179	B. WI	VG		07/-	12/2007
METRO	PROVIDER OR SUPPLIER HOMES			STREET ADDRESS, CITY, 5701 13TH STREET, N WASHINGTON, DC	w		· · · · · · · · · · · · · · · · · · ·
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORRE	PLAN OF CORRECT CTIVE ACTION SHOUNCED TO THE APPRI DEFICIENCY)	II D RE	(X5) COMPLETION DATE
W 441	review of fire drill no Qualified Mental R (QMRP) revealed the had not practiced e of the facility. Most the front exits. The	age 21 ecords and interview with the etardation Professional nat during the past year, staff exiting through all four egresess tire drills were conducted via the was no evidence that ere being held under varied	W 4	41			

Health Regulation Administration PRINTED: 07/18/2007 STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION FORM APPROVED (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER. (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING NAME OF PROVIDER OR SUPPLIER 09G179 COMPLETED B. WING STREET ADDRESS, CITY, STATE, ZIP CODE METRO HOMES 07/12/2007 5701 13TH STREET, NW WASHINGTON, DC 20011 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR LSC (DENTIFYING INFORMATION) TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX TAG (X5) COMPLETE 1 000 INITIAL COMMENTS DEFICIENCY) DATE 1000 A licensure survey was conducted from July 11, 2007 through July 12, 2007. The survey was initiated using the fundamental survey process. A random sample of two residents was selected from a resident population of four females with various disabilities. The survey findings were based on observations in the group home and one day program, and interviews with residents. residential, day program, nursing and administrative staff. Review of records, including investigations of unusual incidents was also 1 090 3504.1 HOUSEKEEPING 1090 The interior and exterior of each GHMRP shall be maintained in a safe, clean, orderly, attractive, and sanitary manner and be free of accumulations of dirt, rubbish, and objectionable odors. This Statute is not met as evidenced by: I 090 Based on observations, interviews and review of Refer to W 104 records, the facility's governing body provided general operating direction over the facility, except in the following areas: The finding includes: The governing body failed to ensure the maintenance of the facility's environment, as evidenced by: a. Front door bell alarm button loose; b. Back bedroom door bell alarm button loose; c. Missing towel bar in the first bathroom on the Health Regulation Administration ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE DZ7Y11

PRINTED: 07/18/2007 FORM APPROVED

Health R	tegulation Administra	ation					
	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NUM		(X2) MULTI A. BUILDIN B. WING _		(X3) DATE SI	
		09G179	CTREET AD	DECC CITY	STATE. ZIP CODE	0171	<u> </u>
NAME OF P	ROVIDER OR SUPPLIER						
METRO	HOMES			H STREET, I STON, DC 2	00 1 1		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIE. MUST BE PRECEDED BY SCIDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
I 1 80	Continued From page 3 4. Cross Refer to W252. The QMRP failed to ensure that Resident #3's Individual Program Plan (IPP) objectives were documented consistently and accurately on the the IPP data collection forms. 5. The QMRP failed to coordinate with the Psychologist to ensure that a simple token calendar program was provided for Resident #2 as evidenced by:			I 180			
	(BSP) dated February 12 recommendation for program to be post	or a simple token cals ed with five blocks fo	12, 2007 endar r each				
-	day for Resident #2. Further review revealed that Resident #2 could earn a star for each time period in which she did not engage in targeted behaviors (self- injurious behavior, property destruction, physical aggression, verbal aggression, non-compliance, screaming and			·	,		
	#2 earned four out an item from a grat QMRP revealed that simple token calend was provided. Furth	of the time period, if I of five stars she could be bag. Interview with the Resident #2 did had at program, however interview revealed.	d pick out the ve a troot data of the the troot data of the troot data		·		
	beneficial and a rev program was being documented evider	It think that the progra rised simple token ca developed. There wance that Resident#2 v ple token calendar pl	lendar as no vas				
l 206	annually thereafter, certification that a h	EL POLICIES or to employment an shall provide a physicalth inventory has been the employee's hea	ician's Deen	l 20 6			

DZ7Y11

Health Regulation Administration

PRINTED: 07/18/2007 FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIE IDENTIFICATION NU		R/CLIA MBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED		
NAME OF	DDD 4050 05 40	09G179		<u> </u>		07/	2/2007
METRO	PROVIDER OR SUPPLIER HOMES		STREET ADDRESS, CITY, STATE, ZIP CODE 5701 13TH STREET, NW WASHINGTON, DC 20011				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY I SC IDENTIFYING INFORMA	Filfi	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULDRE	(X5) COMPLETE DATE
	would allow him or hauties. This Statute is not in Based on interview a failed to ensure that certificates on file. The finding includes: Review of personnel approximately 11:05 evidence of current hautiect staff members pharmacist, Pseconsultants. In an interest of the proximately 12, 2007 at approximately 12, 2007 at approximately during the proximately expressions.	net as evidenced by: and record review, the all staff had current h i records on July 12, 3 AM revealed no docu- lealth certificates for the evidence with the Qualifity rofessional (QMRP) of ately 2:50PM it was the health certifications the survey.	e facility lealth 2007 at imented five and lologist fied on July		I 206 See attached health certificates for and Agency has instituted a computerized data base to monitor all personnel a monthly basis to ensure that on g certifications / records are maintain current status.	zed staff records on	7/23/07
E III	Each training program imited to, the following c) Infection control for this Statute is not me tased on observation, eview, the facility faile accognize signs and syrecautions in one of the Resident #1) and to in	n shall include, but no g: r staff and residents; at as evidenced by: staff interview and resident to effectively train sumptoms of illness and we residents in the samplement emergency our residents in the factories.	ecord staff to id fall ample	1227	I 227 Cross refer to W 192		

HKA

PRINTED: 07/18/2007 FORM APPROVED

Health R	egulation Administra	ation		 -		0/=> 5 4 5 5 6	LIGHTY.
STATEMENT AND PLAN (F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NUI	R/CLIA MBER:	(X2) MULTIF	 -	(X3) DATE SURVEY COMPLETED	
		09G179		B. WING		07/1	2/2007
		030113	STREET ADD	RESS, CITY, S	TATE, ZIP CODE		'
NAME OF P	ROVIDER OR SUPPLIËR	· ·	5701 13Th	STREET, N	ıw		
METRO	HOMES		WASHING	TON, DC 20	0011		
(X4) ID PREFIX TAG	パン・イン・ロック かいかい かいしょう かいしょう かいしゅう かいしゅう かいしゅう かいしゅう かいしゅう しゅうしゅう しゅう	ATEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY LSC IDENTIFYING INFORM/	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
227	Continued From pa	age 5		1 227			
!	The findings include: 1. Interview with the Qualified Mental Retardation Professional (QMRP) on July 12, 2007 at approximately 11:00 AM revealed that all staff was not trained in CPR. Record review on July 12, 2007 at approximately:05 AM revealed that five out of twelve staff did not have current CPR certifications. There was no documented evidence that all direct care staff had CPR training and current CPR certifications.				I 227 Cross refer to W 192		
	approximately 11: was not trained in July 12, 2007 at a revealed that five have current First no documented expressions.	ne QMRP on July 12, 10 AM revealed that a First Aid. Record repproximately 11:15 A out of twelve staff standard certifications. The vidence that all directing and current First Aid certifications.	all staff view on M aff did not lere was care staff			. 0	
1 229	3510.5(f) STAFF			1 22 9	1 229		
	Each training prog limited to, the follo	gram shall include, bu bwing:	it not be		Cross refer to W 189 #4		
	residents to be set to behavior mans	related to the GHMF erved including, but no agement, sexuality, no communications, and a	ot limited utrition,				
	Based on observations and amount of records, demonstrate com-	ot met as evidenced bations, staff interviews, the facility staff failed petency in recognizin illness and implemen	s and the d to g signs			•	

Health Regulation Administration

STATE FORM

DZ7Y11

PRINTED: 07/18/2007 FORM APPROVED

		(X1) PROVIDER/SUPPLI IDENTIFICATION N		(X2) MULTIP A. BUILDING B. WING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		09G179				07/°	12/2007	
NAME OF	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	TATE, ZIP CODE			
METRO	HOMES			TH STREET, NW IGTON, DC 20011				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCE Y MUST BE PRECEDED B' LSC IDENTIFYING INFORM	Y FULL	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETE DATE	
I 22 9		of two clients in the	sample.	1 229				
	recognize signs an Resident #1 as evi Upon entering thre approximately 7:54 observed to be scr pointing to the sec	facility on July 11, 2 IAM, Resident #1 wa earning and crying a ond toe on her left fo	oo7 at as ad			,		
	Attempts to interview Resident #1 were not successful because the client continued to scream and cry. Interview with Direct Care Staff #1, Direct Care Staff #2 and Direct Care Staff #3 on July 11, 2007 at approximately 7;55AM revealed that they had no knowledge of why Resident #1 was screaming/crying and pointing to the second toe on her left foot. Further interview revealed that the direct care staff had not informed the Licensed Practical Nurse (LPN) who was in the facility that Resident #1 was screaming/crying and pointing to the second toe on her left foot. During medication pass observation on July 11, at approximately 7:56 AM, Resident #1 was observed gesturing to the LPN and pointing to the second toe on her left foot and screaming. Interview with the LPN on July 11, 2007 at approximately 8:10 AM revealed that she had assessed Client #1 and had notified the Registered Nurse (RN). Interview with the RN on July 11, 2007 at approximately 9:30AM revealed that the LPN had notified her via telephone that Client #1 was pointing to the second toe on her left foot and screaming. Further interview with the RN revealed that she had notified the Primary Care Physician (PCP) at					, ,		

PRINTED: 07/18/2007 FORM APPROVED

Health I	Regulation Administra	ation		,			WINFFROVED
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE		A. BUILD	TIPLE CONSTRUCTION	(XG) DATE COMPI	
		09G179		B. WING		07 <i>1</i> *	12/2007
NAME OF F	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY	, STATE, ZIP CODE		
METRO	METRO HOMES 5701 13T WASHING			H STREET, STON, DC	NW 20011		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		FULL	ID PREFIX TAG	PROVIDERS PLAN OF (EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENCE	ION SHOULD BE HE APPROPRIATE	OCS) COMPLETE DATE
1 229	Continued From pa	ge7		1229			
	that Motrin 600mg I had been ordered in revealed that the RI nailbeds around Cli- toe were slightly red to monitor Client#1 [Note: Observation July 11, 2007 at app that Direct Care Staff #3	AM concerning Client by mouth three times or pain. Further intent I had assessed that ent #1's left and right and that she would and interview with the proximately 5:00PM ruff #1, Direct Care State participated in an industrial symptoms of illness	a day view the second continue e RN on evealed aff#2 and service				
		to effectively train sta autions for Resident #			F.		
	Manager on July 11 9:00AM that she had night and Direct them that she was cregarding Resident from the night of July frevealed that the Ho the incident and beg officials. Interview what approximately 3:00P ordered bi-lateral hip #1 and she was transroom via the facility medical assessment 12, 2007 at approximat the client has a control of the she was the she was transroom via the facility of the she was transroom that the client has a control of the she was transroom that the client has a control of the she was transroom that the client has a control of the she was transroom that the client has a control of the she was transroom that the client has a control of the she was transroom that the client has a control of the she was transroom to th	served to inform the and 2007 at approximate a fallen in her bedroom ad informed Direct Control of the control	m that are Staff content of the cont				

Health Regulation Administration (X3) DATE SURVEY STATEMENT OF DEFICIENCIES. (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING B, WING 07/12/2007 09G179 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **5701 13TH STREET, NW METRO HOMES** WASHINGTON, DC 20011 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID COMPLETE (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) 1229 1 229 Continued From page 8 Care Plan dated April 22, 2007 on July 12, 2007 at approximately 10:51AM revealed that the client has fall precautions documented as a risk. area. Review of the radiology reports dated July 11, 2007 on July 12, 2007 at approximately 2:30PM revealed that Resident #1 had not sustained any fractures. [Note: Observation and interview with the RN on July 11, 2007 at approximately 5:00PM revealed that Direct Care Staff #1, Direct Care Staff #2 and Direct Care Staff #3 participated in an in-service training on fall precautions on July 11, 2007] 1370 1370 3519.1 EMERGENCIES Each GHMRP shall maintain written policies and procedures which address emergency situations. 1370 including fire or general disaster, missing Cross refer to W 153 persons, serious illness or trauma, and death. This Statute is not met as evidenced by: Based on interview and record review, the facilty failed report incidents that pose a risk to client health or safety to governmental agencies, as required by DC regulation (22 DCMR Chapter 35 Section 3519,10). The finding includes: Review of an unusual incident report dated March 15, 2007 on July 11, 2007 at approximately 7:45 AM revealed that Resident #1 complained of abdominal pain and was transported to the emerency room for evaluation and treatment. Review of an emerency room consult on July 12, 2007 at approximately 10:15 AM revealed that Resident # 1 was diagnosed with constipation. Interview with the Qualified Mental Retardation Professional (QMRP) revealed that the incident

DZ7Y11

FORM APPROVED Health Regulation Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A BUILDING B. WING 09G179 07/12/2007 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **5701 13TH STREET, NW METRO HOMES** WASHINGTON, DC 20011 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETE DATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) 1370 Continued From page 9 1370 was not forwarded to the Department of Health (DOH). There was no documented evidence that this incident had been reported to governmental agencies as required. 3520.2(a) PROFESSION SERVICES: GENERAL 1391 **PROVISIONS** Each GHMRP shall have available qualified professional staff to carry out and monitor necessary professional interventions, in accordance with the goals and objectives of every individual habilitation plan, as determined to be necessary by the interdisciplinary team. The L391 professional services may include, but not be Cross refer to W 322 limited to, those services provided by individuals trained, qualified, and licensed as required by District of Columbia law in the following disciplines or areas of services: (a) Medicine; This Statute is not met as evidenced by: Based on observation, staff interview, and record review the facility failed to failed to provide preventive and general care and failed to implement medical protocols for one of two residents in the sample (Resident #2) The finding includes: 1. The facility's medical services failed to

prescribe glucose monitoring perimeters for

Interview with the Licensed Practical Nurse (LPN) on July 11, 2007 at approximately 2:30PM. revealed that Resident#2 has a diagnosis of Borderline Diabetes Mellitus and that blood glucose measurement utilizing a glucometer is

Resident #2 as evidenced by:

Health R	egulation Administra	ation					••
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIES IDENTIFICATION NUM			(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED		
09G179			B. WING		07/1	2/2007	
NAME OF PROVIDER OR SUPPLIER STREET ADD				DRESS, CITY, S	TATE, ZIP CODE		
				H STREET, NW GTON, DC 20011			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	(X5) COMPLETE DATE	
I 391	prescribed three tir revealed that the P did not indicate any perimeters. Review physician's orders 20077 at approximation blood glucose mean perscribed for Resevidence that blood perimeters perscribed. Cross Refer to N services failed to cappointment for Reservices Refer to N appointment for Reservices Reservices Refer to N appointment for Reservices	mes a week. Further in the primary Care Physically blood glucose meast work of the Resident#2's dated June 1, 200 on ately 2:35 PM reveals asurement perimeters ident #2. There was red glucose measuremoed by the PCP. W331. The facility's nubtain a timely endoor	n (PCP) surement July 11, ed that were not no ent ursing inology	I 391			
. 395	3520.2(e) PROFE PROVISIONS Each GHMRP sha professional staff to necessary professional service individual habilitation necessary by the interprofessional service limited to, those settrained, qualified, a District of Columbidisciplines or area (e) Nursing; This Statute is no Based on staff interprofessional service in the facility failed to entire the professional service in the profession	SSION SERVICES: On the services provided by in the following soft services: If met as evidenced between the services and the following soft services:	ified tor es of every ed to be The not be dividuals red by	I 395	I 395 Cross refer to W 322		

DZ7Y.11

PRINTED: 07/18/2007 FORM APPROVED

Health Regulation Administration STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 09G179 07/12/2007 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 5701 13TH STREET, NW **METRO HOMES** WASHINGTON, DC 20011 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION IΠ (X5) COMPLETE DATE PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) 1 395 Continued From page 11 1395 residents in the sample. (Resident # 2) The findings include: 1. The facility's nursing services failed to ensure that Resident #2 returned to the endocrinology clinic as recommended as evidenced by: Review of an endocrine consult dated February 2, 2007 on July 12, 2007 at approximately 1:00PM revealed that Resident #2 was recommended to return to the endocrinology clinic in four months. In an interview with Licensed Practical Nurse (LPN) on July 12, 2007 at approximately 1:08 PM it was acknowledged that Resident #2 did not return to the endocrine clinic in four months. There was no documented evidence that Resident #2 returned to the endocrinology clinic in four months as recommended by the endocrinologist. [Note: Interview with the LPN on July 12, 2007 at approximately 1:15PM revealed that Resident #2 was being scheduled for an endocrinology appointment on August 20, 20071 2. The facility's nursing services failed to obtain timely laboratory studies for Resident # 2 as recommended by the Endocrinologist as evidenced by: Review of an endocrine consult dated February 2, 2007 on July 12, 2007 at approximately 1:02PM revealed that Resident #2 was recommended to have a Hemoglobin AIC laboratory study performed in four months. In an interview with Licensed Practical Nurse (LPN) on July 12, 2007 at approximately 1:09 PM it was acknowledged

Health Regulation Administration

that Resident #2 did not have a Hemoglobin AIC

Health Regulation Administration (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A BUILDING B. WING _ 07/12/2007 09G179 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 5701 13TH STREET, NW WASHINGTON, DC 20011 **METRO HOMES** PROVIDER'S PLAN OF CORRECTION (X5) SUMMARY STATEMENT OF DEFICIENCIES 1D COMPLETE (EACH CORRECTIVE ACTION SHOULD BE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE PRÉFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) 1395 Continued From page 12 1 395 laboratory study performed in four months. There was no documented evidence that Resident #2 had a Hemoglobin AIC laboratory study performed in four months as recommended by the endocrinologist [Note: Interview with the LPN on July 12, 2007 at approximately 1:20 PM revealed that Resident #2 was being scheduled for a Hemoglobin AIC laboratory study on August 15, 2007] 1436 1 436 3521.7(f) HABILITATION AND TRAINING The habilitation and training of residents by the GHMRP shall include, when appropriate, but not be limited to, the following areas: (f) Health care (including skills related to nutrition, use and self-administration of medication, first I 436 aid, care and use of prosthetic and orthotic devices, preventive health care, and safety); Refer to W 130 This Statute is not met as evidenced by: Based on observation and interview, the failed to ensure privacy was provided during care of personal needs for one of two residents residing in the facility. (Resident #1) The finding include: On July 11, 2007 at approximately 7:55 AM, Resident #1 was observed sitting on the commode while the bathroom door was open. The commode and Resident #1 were visible from the front door of the facility. When nursing staff entered the bathroom to assist the client, they did not close the door. Interview with nursing staff revealed that the resident needed reminders to close the door when she used the bathroom.

Nursing staff were not observed offering Resident

PRINTED: 07/18/2007 FORM APPROVED

Health Regulation Administration (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING B. WING __ 07/12/2007 09G179 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 5701 13TH STREET, NW **METRO HOMES** WASHINGTON, DC 20011 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) 1436 1436 Continued From page 13 #1 a reminder that morning. There was no evidence that nursing staff ensured the resident's privacy while using the bathroom. 1 442 3521.7(I) HABILITATION AND TRAINING 1 442 The habilitation and training of residents by the GHMRP shall include, when appropriate, but not be limited to, the following areas: (I) Time management (including use of leisure time, scheduling activities); I 442 This Statute is not met as evidenced by: Cross refer to W 153 & W 159 Based on interview and record review the facility failed to ensure that all resident program objectives were formulated to provide measurable indices of performance for two of two residents in the sample. (Resident #1 and Resident #2) The findings include: 1. Review of Resident #1's Individual Program Plan (IPP) dated May, June and July 2007 on July 12, 2007 at approximately 1:45 PM included the following money management objective: Take item receipt, take change and take item with verbal prompt. In an interview with the Qualified Mental Retardation Professional (QMRP) on July 12, 2007 at approximately 1:50 PM it was acknowledged that the program had multiple criteria for mastery and was not measurable. There was no evidence that the measurement criteria provide measurable indices of performance at each level.

DZ7Y11

Health Regulation Administration (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A BUILDING B. WING _ 07/12/2007 09G179 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **5701 13TH STREET. NW** METRO HOMES WASHINGTON, DC 20011 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID COMPLETE (EACH CORRECTIVE ACTION SHOULD BE (FACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) 1442 1442 Continued From page 14 2. Review of Resident #2's Individual Program Plan (IPP) dated May, June and July 2007 on July 12, 2007 at approximately 1:55 PM included the following money management objective: Take item receipt, take change and take item with verbal prompt. In an interview with the QMRP on July 12, 2007 at approximately 2:00 PM it was acknowledged that the program had multiple criteria for mastery and was not measurable. There was no evidence that the measurement criteria provide measurable indices of performance at each level. 1500 1500 3523.1 RESIDENT'S RIGHTS Each GHMRP residence director shall ensure that the rights of residents are observed and protected in accordance with D.C. Law 2-137, this chapter, and other applicable District and federal laws. I 500 Cross refer to W 124 & 125 This Statute is not met as evidenced by: Based on observation, interview and record verification, the facility failed to ensure the right of each resident or their legal guardian to be informed of the resident's medical condition, developmental and behavioral status, attendant risks of treatment, and the right to refuse treatment for two of two residents in the sample. (Resident #1 and Resident #2) The findings include: 1. Observation of the morning medication administration on July 11, 2007 at approximately 8:00AM, revealed Resident #1 received Loxitane 50 mg by mouth. Interview with the nursing staff

DZ7Y11

PRINTED: 07/18/2007 FORM APPROVED

Health Regulation Administration

i leaill F	Regulation Administra	allon						
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIDENTIFICATION N			(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED			
09G179		09G179		B. WING _		07/12/2007		
NAME OF F	PROVIDER OR SUPPLIER	1	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
5701				NGTON, DC 20011				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TH DEFICIENCY	(X5) COMPLETE DATE		
I 500	on July 11, 2007 at revealed that the medical procedures client's Psychological 2007 on July 11 10:15AM revealed a legal guardian. FResident #1's broth medical procedures client's legal guardi #1's Psychological 2007 on July 12, 20 indicated that the remake independant concerning medical There was no docu facility informed Relegally-authorized rof the health benefit associated with the medications and concerningly, the fact that substituted corrections or concerningly, the fact that substituted corrections are concerningly, the fact that substituted corrections or concerningly the fact that substituted corrections or concerningly the fact that substituted corrections and concerningly, the fact that substituted corrections or concerning the concerning that	t approximately 8:01A nedication was prescriptent. Review of the redated June 1, 2007 of tely 10:00 AM revealed mouth twice a day a every evening was incort Plan (BSP) dated of the property	ribed for resident's on July 11, ed that and Atarax corporated d April 12, with pubic h the hal tely not have ealed that ts for her the esident April 11, 10:45AM stent to as eatment. at the propriate, ment opic evidence	1 500			ā	
	administration on J 8:30AM, revealed F 300 mg by mouth a Interview with the n at approximately 8:	he morning medication Iuly 11, 2007 at appropriate appropriate appropriate and Loxitane 50 mg to the staff on May 131AM revealed that the scribed for behavior	oximately Clozaril by mouth. 15, 2007 the			*		

PRINTED: 07/18/2007 FORM APPROVED

Health Regulation Administration (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING B. WING 07/12/2007 09G179 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **5701 13TH STREET, NW** METRO HOMES WASHINGTON, DC 20011 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PREFIX PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) 1500 Continued From page 16 1500 management. Review of the resident's physicians orders dated June 1, 2007 on July 11, 2007 at approximately 10:15AM revealed that Clozaril 300 mg and Loxitane 50 mg by mouth twice a day was incorporated in a corresponding BSP dated February 11, 2007, to address behaviors associated with self-injurious behavior, property destruction, physical aggression, verbal aggression, non-compliance, sreaming and crying. Interview with the QMRP on July 11, 2007 at approximately 10:20AM revealed that Resident #2 did not have a legal guardian. Further interview revealed that Resident #2's mother signs the consents for her medical procedures, however she is not the client's legal quardian. The review of Resident #2's Psychological Assessment dated February 11, 2007 on July 11, 2007 at approximately 1:50 PM indicated that she is unable to grant informed consents in a legall competant manner regarding medical care. There was no documented evidence that the facility informed Resident #2 or a legally-authorized representative, as appropriate, of the health benefits and risks of treatment associated with the use of her psychotropic medications and corresponding BSP. Additionally, the facility failed to provide evidence that substituted consent had been obtained from a legally recognized individual or entity. 3. Interview with the Qualified Mental Retardation Professional (QMRP) on July 11, 2007 at approximately 10:15 AM revealed that Client #1's brother was active in her life. Review of a medical consult, dated July 5, 2007 on July, 2007 at approximately 2:50PM revealed that Client #1's brother signed the consent for a colonoscopy, however he was not the legal quardian. The review of Client #1's Psychological Assessment dated April 11, 2007 on July 12.

DZ7Y11

Health R	egulation Administra	ation			<u> </u>		··	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		- COMPLI	(X3) DATE SURVEY COMPLETED		
		09G179		B. WING		07/1	2/2007	
NAME OF P	ROVIDER OR SUPPLIER				TATE, ZIP CODE	•		
5701 13TH				H STREET, NW GTON, DC 20011				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE		
I 500	Continued From page 17			I 500		•		
	client is not compe informed decisions psycological treatm the client had a leg	tely 10:45AM indicate tent to make indepension concerning medical ment. There was no exally-sanctioned guard health care decision the colonoscopy.	ndant or and vidence dian					
					·			

DZ7Y11